

The structure of the training-cum-research-seminars

Its implications for medicine*

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I

THE number of general practitioners—according to various statistics—is steadily declining, some people honestly think that general practice is dying out. Is this true? To my mind what happens is that the functions of the general practitioners are gradually taken over by doctors who, having a training in some speciality, feel they ought to be called by some more important names. Some of them are called according to their speciality, others use names like: family doctor, specialist in family care, primary physician, and so on. Coming from England where general or family practice is perhaps having a renaissance, I shall use ‘general practitioner’ and ‘general practice’ throughout my address, but wish to stress that these names are meant to include all doctors who are prepared to take care of the whole patient, or of the whole family.

Almost all postgraduate seminars—no matter whether intended for general practitioners or for doctors wishing to specialize—are structured according to the traditional teacher-pupil relationship. The teachers are practically always specialists who, by definition, know more, while the pupils—no matter whether general practitioners or intending specialists—proclaim openly by their attendance at the course that they know less.

This structure determines what happens in the course. The intention of the teachers is always to hand over some of their superior knowledge and some of their consummate skills to the pupils. This they do by lecturing about their knowledge on the one hand, and by demonstrating their skills on the other. Thus the teachers are always *active* while the pupil's rôle is more or less *passive*, that is they are supposed to ‘take in’ what is offered to them by the teachers. True, at times the pupils may report about their observations or show some of their skills, but all this happens with the openly admitted aim that both their observations and their skills should be corrected, be improved. In this way most contributions come from the teachers, while almost all the learning is done by the pupils.

This dynamic structure has certain unavoidable consequences, some desirable, others undesirable. First, a permanent inequality between teachers and pupils is established, learning can take place only after the teacher's superiority and the pupils' comparative inferiority have been accepted all round. This, as we all know, causes considerable ambivalence on both sides, some of it openly admitted, some of it remaining

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unconscious. Another, a welcome, consequence of the structure is that the course can be planned, since according to the basic assumption the specialist knows his field, and therefore knows which parts of his knowledge he should try to hand over to the pupils during the time available, it is he who decides how long the course should last, what he should lecture about, and in what order.

Although occasionally it is permitted or even asked, that the pupils should voice their wishes, it is almost always the specialists who have the last word. This must be so since the responsibility for the whole course is theirs.

Apart from very few exceptions, all courses organized by us psychiatrists for general practitioners are structured along these lines. As a rule, they are advertised under some such names: 'Psychiatry in general practice' or 'Psychotherapy for general practitioners', etc. It will be important for our discussion to spell out the not explicitly stated, merely tacitly accepted assumptions, which justify this procedure: (i) the psychiatrist knows what sort of psychiatric problems occur in general practice, that is, what sort of psychiatry it is that the general practitioners need; (ii) he also knows what sort of therapy, especially psychotherapy, is possible and desirable in general practice; and (iii) the psychiatrist is not only familiar with both of them but is able to teach them to a satisfactory standard in the time available in an average postgraduate course. On the basis of our experiences it seems that there is only some but not much truth in any of these three assumptions. Before discussing the validity of this statement I should like to say something about our training scheme.

II

We call our scheme Research-cum-Training-Seminars, and I should like to add that ever since the very first one in 1950 they have been announced in the medical press under the title 'Discussion seminars on psychological problems in medical practice' (or in general practice).

There are a few points that I should like to emphasize. First, we psychiatrists do not teach—at any rate we try very hard not to behave as teachers. Instead, we try to establish the spirit of a research team consisting of the participating general practitioners and ourselves. The aim of the research is then to discover:

- (a) What the psychological problems in every day general practice are;
- (b) How to recognize and understand them; and
- (c) How to use our knowledge and understanding so that they should have a therapeutic effect on the patient.

On their face value these sound very innocent propositions. Of course, one ought to study the whole range of psychological problems encountered in medical practice, try to understand them and devise techniques for influencing them therapeutically. No one can have any objections against them. Although this is true, these three propositions have very far reaching implications both for training and for medicine in general. As soon as the psychiatrist stops lecturing about his own knowledge, he soon realizes that general practice is fundamentally different from hospital practice. This has been an accepted truism—but only in a one-sided way. Hospital practice was considered as the *true* medicine, whereas general practice—in fact anything outside the inpatients service of a good hospital—was looked upon as a very poor second-rate edition of real medicine. What we discovered is that this is not so. Properly conducted observations in general practice are as valuable, as scientific, as properly conducted observations in the somewhat artificial, almost laboratory-like, conditions of a hospital ward. I shall end my address by discussing some of the consequences of this discovery for medicine in general.

At this point we shall be concerned only with its importance for the psychiatrist's

rôle in the training-cum-research-seminars. If, as we have found, events and problems are encountered in general practice which are unknown in hospital practice, it follows that the general practitioner in many respects will know more about them than the psychiatrist who has never met them. With this the one-sided teacher-pupil relationship loses all its justification and all members of the research team become in the first approach equal, each of them teaching and learning at the same time. This was literally true in the first five to ten years of my work in this field, and to a great extent it is still true now after almost 20 years of experience. Of course, the experiences of these long years have taught me a good deal. I am no longer the naive psychiatrist for whom every seminar meeting was an exciting experience, full of new discoveries. This has passed but I am not at all certain whether my leadership has become the better or the worse for it.

The three propositions mentioned above mean a great change also for the doctors. Most postgraduate courses take the doctors out of their practices, place them into some hospital or institution, that is, the psychiatrist's world. This can be done only if the duration of the course is limited, say, a day, a weekend, or one or two weeks at the most. As our material is the doctor's observations in their own practices we had to create conditions which were compatible with an ongoing undisturbed practice. A great advantage of this arrangement was the possibility of a long-term, continuous follow-up of any case discussed—which of course is incompatible with the short-lived seminars.

A further consequence of the discovery mentioned above is that we cannot have pre-arranged time tables. When the psychiatrist realizes that his knowledge, although important, is not all that matters, he cannot plan the course on that basis any longer. Our seminars are based on a spontaneous participation without any prepared agenda, each doctor volunteering to report about this or that of his patients with psychological problems whenever he chooses. This sounds rather unsystematic and at first glance it is definitely so. However, if one follows the sort of cases that are recognized by the doctors as psychological problems at any one time one soon becomes aware of a sort of inherent system which reflects the spirit of the time, the composition of the seminar, the stage and rate of development of the participants, etc., that is, which grows naturally out of the research work and has not been imposed on it from outside.

These case reports about psychological problems and their handling form the basis of our discussions. If at all possible we try to encourage all participants to take part in it, disclosing what each of them feels and thinks about the problem and its management. The discussion is steered in a way that criticisms are couched in the form of recommendations about handling the case and, still more important, in the form of predictions about what the consequences of this or that sort of treatment will be. I wish to stress here that each general practitioner remains in full charge of his patient and thus has to accept full responsibility for the therapy chosen by him. As the doctor remains in his practice all the time the follow-up is automatic for all the cases reported, with the consequence that no doctor can escape realizing whether he was right or wrong, and whether and how far the criticism against him was proved correct or otherwise by the events.

Perhaps I can add here something about the psychiatrist's changed rôle in the team. As mentioned he tries to be an equal member, not more and not less than any of his colleagues, but with important differences. In some ways he is the one who knows least. To quote a few impressive examples: Very few psychiatrists have first hand experience of psychotherapy conducted while palpating the patient's abdomen or performing a vaginal or rectal examination, although these are fairly common events in general practice; it is very rarely that a psychiatrist meets a patient and has a few therapeutic words with him while he is exercising his dog in the nearby park, accompanies his wife to a public function, or takes his children to school. On the other hand there

are areas in which he knows incomparably more than any of the other participants. In my case—I am a psycho-analyst—my knowledge of the unconscious forces and processes, my familiarity with the subtleties of transference manifestations are unquestionably greater, though limited. Almost everything that I know is conditioned by the psycho-analytic situation which is an exclusively two-person relationship in which any third person is unavoidably a hardly tolerable intruder. In contrast the general practitioners, as a rule, are real family doctors, that is, they create and maintain transference relationships which include the whole family, that is four, six and even more persons—an area of which the analyst knows but little.

This double quality of our rôle—knowing much more in certain respects and much less in others—determines the nature of our participation. We are learners in many ways, and teachers in others. It is important that we should perform this double function honestly and openly, because without our frank admission that we too are learners all the time, we tacitly accept and even reinforce the myth about the omniscient specialist. The general practitioners need some time to realize the falsity of this myth and to overcome it. *Pari passu* they also discover that psychological problems encountered in their practices are really problems of human relationship which the patients cannot solve in their own environment and must therefore transfer—on to their doctors. Because of our familiarity with the unconscious and with transference manifestations, we psycho-analysts can contribute—more often than any other of the participants—something relevant to the elucidation and understanding of these phenomena. It is in this way that we come to be regarded as leaders of the group, representing the aims and standards of the research work. Everyone who has been able to travel this far will agree with me that this is a much more rewarding rôle than that of the omniscient specialist. All this has very important effects on medical thinking and on therapeutic approach; we shall have to return to it shortly.

III

The next question must be: If there is no teaching in the seminars what does happen in them? Will you allow me to confound the confusion a bit more? I mentioned several times that most postgraduate courses are of short duration, a weekend, a week, or—at most—a fortnight. Compared with them our seminars take an enormous amount of time. Each of our weekly meetings lasts about two hours and as a rule we have about 40 of them in a year. When joining the courses the doctors are warned that they should not expect any great change in their psychological understanding or psychotherapeutic skills for the first one or two years, the real fruits of their work will become available, as a rule, in the third year. This would mean about 240 hours all told. A good proportion of the doctors are satisfied with this much, but a fair number of them decide to continue to attend for some more years.

Let us now return to our main topic—with these figures in hand—and ask: What on earth does happen in these seminars? In particular, is this something worth the enormous amount of time spent on it?

A complete answer to these questions would amount to an extensive monograph on training doctors in psychological understanding and psychotherapy; the reason for it is that numerous interlinked processes, with rather subtle dynamics, have to be followed in considerable detail. Space permits only a highly condensed and simplified approximation.

If this can be accepted, the events in our seminars may be grouped under the

following three headings:

1. Learning
2. Unlearning and
3. Relearning.

These three headings correspond roughly, but not at all exactly, to three phases in the development of every group of participants. Phase 1 (learning) starts very soon after the inception of the meetings, in the second or third month, and continues during the whole lifetime of that particular group—of course, with great variations in speed, intensity, and depth. Phase 2 (unlearning) starts as a rule about the end of the first or the beginning of the second year. As we shall see presently, because of its nature, it can perhaps never end. Phase 3 (relearning) starts still later and thus not every participant reaches it.

I would like to add here a few remarks. The most important is that these three phases are valid, more or less, for everyone who attends our seminars for any length of time, no matter whether he is a general practitioner, a psychiatrist, a psycho-analyst, or whether he is a regular member, an associate or merely a visitor for a limited period. My second remark is about the word 'relearning' which is only a moderately acceptable term for the description of what I have in mind; 'training' would be, in many respects, more suitable, but still not quite correct; a still better word would be 'discovering', this would offer me the word 'rediscovering' for the description of the third phase, but would leave me without a name for the second phase because 'undiscovering' is meaningless.

IV

So let us start with a very condensed summary of the phenomena which can be summed up under the heading 'learning' or 'discovering'. Perhaps the most surprising of these discoveries is that the most frequently prescribed drug in medical practice is the doctor himself. The customary treatment of this very old and respectable discovery is to leave it alone and not to link it to the closely associated discovery that this drug has absolutely no pharmacopoeia. We have no literature on its indications, its curative and maintenance dosage, its toxicity, its avoidable and unavoidable side effects, its contra-indications, and so on.

In the first instance, learning in our seminars, is learning about these neglected problems of pharmacology, in particular, about the special variety of the drug represented by each individual doctor, that is, what sort of drug he himself is. In this way, the doctor gradually discovers his individual way of behaving in his practice, how he 'practises' medicine, how he treats patients with problems.

The doctors realize that, especially, a problem patient 'offers' to them a number of symptoms, syndromes or even illnesses to which the doctor cannot but respond by various examinations such as the classical clinical routine, x-rays, straight or using various contrast substances, microscopical or chemical examinations, and so on, or even by sending the patient to a specialist. On the basis of all these examinations, the doctor prescribes some drugs, or a diet or gives therapeutic advice. In this way an interplay develops between doctor and patient, the patient either maintains his 'offers' or changes them under the impact of the various examinations and treatment, and the doctor in the same way either perseveres with them, or 'responds' by changing his examinations or his treatment. In the case of problem patients, the result of this interaction is an 'agreement'. From then on, doctor and patient know "what the trouble is about".

Once it can be admitted in principle that the 'agreement' is determined partly by the patient's illness, but partly by the doctor's way of 'practising medicine', many further important 'discoveries' will follow, some pertaining to the doctor himself. The particip-

ants soon realize that there are as many ways of practising medicine as there are doctors; events that happen quite naturally in one doctor's practice would be utterly impossible in another's. Yet each of these different ways has its own therapeutic effect in certain cases.

In the light of the 'discovery' of these individual differences, the doctors become more sensitive to their own contributions to the developing doctor-patient relationship, especially to that kind which we call their 'apostolic function'. Apparently, each doctor is convinced not only that his way of practising medicine is the only right one, but also feels that he has the sacred duty to preach it and convert, thereby, all the heathens and unbelievers, both among his patients and his colleagues, to his ways. The fact that each doctor succeeds in building up a practice around himself shows that this conversion takes place in many of his patients—though not in so many of his colleagues.

So far, we have discussed the discoveries about the doctors' hitherto unnoticed powers. There is comparable power in the patients too. It is uncanny how certain patients, many more than one would like to admit, can create a certain form of relationship between themselves and their doctors, and how difficult it is for us doctors to avoid being involved in this particular way with this patient.

It is in this way that the doctor reaches the first gains in his therapeutic potential:

1. By becoming aware of the force of his own 'apostolic function' he gradually frees himself from its compulsive power.
2. This helps him to recognize his own emotional 'responses' while attending to his patient, in particular, the interplay between his responses and the patient's powerful behaviour patterns; the recognition of this interplay enables him to notice and control his otherwise automatic reactions.
3. If the two previous tasks can be performed fairly reliably, the patient's patterns emerge more clearly, which helps the doctor to become still less emotionally involved, thereby opening more possibilities for planned therapeutic interventions.

From another angle, this is the beginning of what we called the "considerable though limited change of the doctor's personality" which in our experience is the precondition for the acquisition of any psychotherapeutic skill.

I wish to end the description of this phase by mentioning, though very briefly, one of our theoretical discoveries. We found it therapeutically profitable to divide the pathological conditions presented by our patients into two classes. Class I comprises the conditions in which a localizable 'illness' can be found. This is the true field of the specialist, of scientific or hospital medicine. Our exact scientific examinations can find and identify the fault, and can thus lead us to what we call a 'traditional diagnosis' on the basis of which we can devise a 'rational therapy'. We try to describe these patients as people who have an 'illness'.

In contrast to them, there are people who have no localizable illnesses, but are 'ill' themselves. The most exact scientific examination cannot identify in them any localizable fault; nevertheless, these people are ill, sometimes severely ill. These suffer from a Class II pathological condition. In their cases, any attempt at a traditional diagnosis is either futile, or the diagnosis refers only to an irrelevant or a temporary condition, not to the real pathology. The interplay between 'offers' and 'responses' can be studied easily in their cases, and so can the very great and real dangers of reaching an irrelevant 'agreement'. As there is no real 'traditional diagnosis', what is treated is almost always the spurious 'agreement'.

To contrast the two different ways of practising medicine, we call the first 'the illness-centred medicine'. This is taught in every teaching hospital, and almost exclusively by scientifically minded specialists, its aim is to identify a localizable fault in the patient which is then called illness, diagnose it properly in traditional terms and devise on this basis a rational therapy. As we all know, this 'illness-centred medicine' has had

spectacular successes with Class I pathological conditions but proved inadequate with those belonging to Class II.

We learnt to contrast it with the 'patient-centred medicine' which, in addition to studying the parts and part function of the body in order to discover any localizable illness, tries to study the whole person in order to reach an 'overall diagnosis'. Unfortunately, this medicine is in its infancy. It has not yet developed a system comparable with the illness-orientated medicine, nor has it worked out a systematic therapy. This is a very tricky problem; when discussing phase III we shall have to come back to it.

V

May I recall here what I said in section III that the dividing line between the phases is anything but clear. Phase II, unlearning, starts well before the clear realization of the difference between illness-orientated and patient-orientated medicine, but it receives an important impetus from it. The doctors gradually discover that in Class II conditions present-day medical thinking which presumes that every ill person must have a localizable illness is incorrect and, in consequence, in certain cases the doctor's prime task, to identify this illness, simply cannot be performed. May I add here that the frequency of Class II conditions in general or primary medical practice is much higher than in hospital practice. The simple reason is selection: Only the 'interesting' cases are referred to hospitals by general practitioners and kept there by the specialists.

In this way, the doctor 'unlearns' his unlimited beliefs in the traditional diagnosis. He realizes that it is important and even life saving in Class I conditions, but also that in Class II conditions what is dished up as traditional diagnosis is often irrelevant or even misleading. In the same way, he unlearns some of his respect for the results of laboratory and specialist examinations which are useful only as far as they can lead to a proper traditional diagnosis, that is in Class I conditions. In Class II conditions, an over-zealous use of laboratory and specialist examinations may be even harmful because it diverts the patient's attention from his personality problems and conflicts to irrelevant reports about the state and function of his organs. As we all know, in many cases this undesirable effect can not be changed even though the report says 'nothing abnormal found'.

Perhaps the most difficult task of this 'unlearning' is the change of attitude towards medical history-taking. The aim of a medical history as it is taught in the teaching hospital is to collect data for the identification and localization of the illness that is presumed to exist in every patient. Medical history-taking and the classical clinical examination that follows it are the two fundamental techniques—precise and reliable, subtle and efficient—an achievement of which we doctors can be justly proud; but they have been developed in the service of illness-orientated medicine, and have hardly any usefulness for the person-centred medicine. Although this ought to be as clear as daylight, we found that whenever a doctor got into difficulties, he tended to revert to the old ways of medical history-taking. Apparently, it is an exacting demand to give up something of which one is proud and which has proved most useful in many difficult situations.

I should like to sum up now the changes in the doctor's ways of practising medicine that follow these developments. Above all, there will be more individual responsibility for him, some of the causes for it are:

1. He realizes the limitations of the help that he may expect from the laboratories and from his specialists.
2. He cannot rely without any further scrutiny on the traditional concept of illnesses in Class II or mixed conditions for devising his therapy: to quote some instances, patient complaining of sadness—traditional diagnosis, depression: Therapy, antidepressants. Patient complaining

of agitation and anxiousness—traditional diagnosis, anxiety state: Therapy, sedatives or tranquillizers, and so on.

3. Instead of asking questions and collecting the disjointed answers into a medical history, the doctor has to listen and understand the meaning of what the patient tries to communicate to him in order to arrive on that basis to our overall diagnosis. This latter leads to the introduction of 'long interviews' lasting from three quarters of an hour to an hour, which may break up his accustomed routine.

I think it is fair to say that all over the world the average time that a patient gets from a general practitioner or primary physician is about 15 minutes. I wish to stress the average time. In this way, the long interview that is the patient-orientated medicine remains a sort of foreign body, not an integral part of the doctor's daily work. With this, we have arrived at Phase III.

VI

I must admit that for many years I did not realize either the existence or the importance of what we now call 'relearning'. What I thought was that with the end of Phase II, the training side of the training-cum-research programme was terminated; what remained was—as in any other branch of science—further research. And equally, as in any other branch of science, further research led to learning something new, so in our field further research will teach us something new. In this way, from fairly early on in our history, we organized research seminars with the aim of studying special problems in general practice. It was only gradually that it dawned on us that the problems that we were studying had something in common which was how to integrate our new knowledge and skills with the traditional hospital or scientific medicine, or if you allow me to use our new terminology—how to integrate the illness-orientated and the person-orientated medicine into one.

From that angle, relearning can be formulated in this way: After having acquired more knowledge and better skills, how can a practising doctor avoid a split in himself, to be a general practitioner to some of his patients, and a competent psychotherapist to others? Or, expressed in our new terminology, how can he avoid practising illness-orientated medicine with some, and person-orientated medicine with others of his patients?

Looking back at our previous studies, since about 1957 from this point of view we realized that one of their motive powers was this need, though, of course, not recognized by us. To show what I mean, may I quote—in chronological order—our studies of *Night calls* (Max B. Clyne 1961), *Unconsummated marriages* (L. J. Friedman 1962), *One man's practice* (R. S. Greco and R. A. Pittenger 1966), *Asthma* (A. Lask 1966), and so on. One of our tasks was, in all these studies, to reformulate the tenet of the illness-orientated medicine in the terms of patient or person-orientated medicine. We invariably found that if this can be done, the doctor will be able to observe what happens between his patient and himself better and more reliably; this will lead to sharper descriptions and definitions which, in turn, will enable us to see some hitherto hidden problems more clearly. I hope you realize that with this, we completed a circle and returned to our very first discovery of the study of the doctor's function as a drug, and of the study of his apostolic function.

As the result of this realization, in the last three or four years, we have organized seminars with the specific aim of studying the problems and difficulties of this integration, or relearning. As they have been running only for a relatively short time, in place of a general conceptualization, all I can offer is an interim progress report of the various research projects undertaken.

One team of doctors has been studying for more than two years what can be done,

using these new skills, during the 10 to 15 minutes that a patient gets. Our aim is to study how the new psychological understanding and the traditional prescribing of drugs can be integrated into a united, better aimed and more reliable therapeutic action. In order to control all the relevant factors, the doctors have to report in writing:

1. What they knew about the patient and his family before this particular visit.
2. Why the patient came on this occasion.
3. What the doctor learned during this visit.
4. The traditional and the overall diagnoses with the therapeutic decision and actions based on each of them.
5. The patient's reactions to these actions.
6. The doctor's predictions, both in terms of the traditional and the overall diagnosis, both for short and long term.

This record is then reported to the seminar where it is first discussed and criticized, after which we add to it our comments and amendments. This, too, is taken down in writing. Then, at regular intervals, we follow up all the cases reported. To date we have about 60 cases documented in this way.

This research was started early in 1966 and we have just begun to sort out some of the results, which means that all our formulations are rather tentative. Still, here are some of them:

- (1) In our experience, it is possible to isolate the effects of illness-orientated therapy, say in the form of drugs, from person-orientated therapy which is based on a proper overall diagnosis, and then to follow up when and under what circumstances the one enhances or diminishes the effects of the other.
- (2) In cases where only an incomplete overall diagnosis could be achieved, there is a tendency in some doctors to revert to an automatic and unnecessary prescribing of drugs with easily predictable therapeutic failure.
- (3) We are not yet in a position to define what can and what cannot be done during the 10 to 15 minutes, but we can say that although the therapeutic possibilities are limited, they are much greater than we expected.

Another group of doctors is studying repeat prescription patients, that is, patients who—often for many years—receive the same medication. In our opinion, this is a symptom of a pathological condition of the doctor-patient relationship, and we think that is why, until now, the illness-orientated medicine has paid so little attention to it, although its occurrence has been well known. According to our figures, the number of patients who receive a repeat prescription is about 25 per cent of all patients seen.

Studying this group, we found—as was to be expected—that these patients receive many more drugs that act on the central nervous system than the control group which consisted of non-repeat patients treated by the same doctors; and also that in the repeat group, there were many more 'debateable' prescriptions than in the non-repeat group—demonstrating the embarrassment of the illness-orientated medicine *vis-à-vis* these patients. In many cases of the repeat prescription patients, we could observe a characteristic development of the doctor-patient relationship. At the beginning, before the onset of the repeat régime, a sort of struggle existed. Many laboratory examinations were asked for and quite a number of specialist examinations, the drugs were often changed, and so on; then after the start of the repeat prescription a sort of 'peace' set in, hardly any laboratory examination and referrals to specialists, the open struggle disappeared but only to go underground, the doctor-patient relationship remained in the state of uneasy truce.

Quite briefly, I shall mention one more research project which had a great emotional impact on all of us. This was the study of the doctor-patient relationship in the terminal phases of an illness. As you all know, the general tendency is to 'spare the patient'. In practice, this means to be generous with sedatives, tranquilizers and pain killers but

on no account to tell the patient that he is seriously or even mortally ill, so as to keep up his hope in the possibility of an improvement, even to the extent of quite considerable deviation from the obvious truth. Studying such cases in detail, we almost invariably found an increasing strain between the doctor and his patient, amounting in certain cases to suspicion and mistrust, a general atmosphere of deception.

Then, very timidly at first, we began to experiment with sincerity. That meant watching carefully for the patient's faint, often half-hearted attempts at asking questions of the doctor and answering them, never brusquely, but always absolutely honestly—even when it meant saying in so many words that, as far as medical experience can tell, the patient had only a very short time to live.

To the very great surprise of most of us, in most cases, the result was the disappearance of mistrust and suspicion and the development of a peaceful, friendly and grateful atmosphere, not only between the patient and his doctor but also between the patient and his family.

We have not had time enough to study a sufficiently convincing number of cases, so our results must be taken with some caution. However, almost all reports speak about a most moving experience; the visit to the dying patient which was dreaded until the honest discussion became a valued part of the doctor's weekly routine which enabled him to administer to his patient, to visit a friend, to witness how the friend takes leave from life, and mourn openly with him and his family. A further, quite unexpected observation was that the amount of sedatives, tranquillizers and pain killers needed after the honest discussion was incomparably lower than usual—a rather impressive demonstration of how much the illness-orientated therapy can benefit from the integration with patient-orientated therapy.

VII

Until now only the changes in the participating doctors, that is, general practitioners or primary physicians, were discussed. The single, very passing remark that was made about the psychiatrists or psycho-analysts was that they, too, went through the three phases of learning, unlearning and relearning, as the general practitioners. Although we know that this is the case, our knowledge of the processes involving them is incomparably poorer than of those pertaining to the general practitioners.

Of the many reasons why this is so, may I quote a few here: First, we could observe many more general practitioners than psychiatrists or psycho-analysts; a rough estimate would put this proportion to ten to one. Second, our chief attention was focussed on the training of general practitioners while the training of psychiatrists was only of secondary importance to us. Third, as we all know, it is much easier to observe someone else than ourselves; the nearer the object of observation resembles oneself, the harder is the task of observation.

After this preamble, let us start with some of these processes belonging to Phase 1, 'learning' or 'discovering'. The most important of these discoveries is perhaps the realization that each medical setting has its own therapeutic, or more correctly, whole-person therapeutic potential. These cannot be studied from the outside, especially not when using preconceived ideas which—because they were developed in another setting—are inapplicable to the setting in question. This truism is not easy to accept, and particularly not by psycho-analysts. Our everyday practice proves so convincingly what a powerful therapeutic tool the classical psycho-analytic situation is. Under the influence of this experience, we find it almost impossible to accept that other medical settings may be worth studying because they, too, have their specific therapeutic, and even strictly psycho-therapeutic potential. A further point, which is of especial import-

ance for psycho-analysts, is that the clinical phenomena observed in these other medical settings may represent certain stages or phases of human development which, perhaps, cannot be reproduced in the analytical situation or, if they can, they cannot be recognized easily. What I have in mind here is the patient's relationship to physical pain, to the feeling of being ill, to his temporary or lasting incapacity and so on. We know that these experiences are highly important for mental economy, for ego-theory, etc., but we cannot yet integrate them into our various theoretical or chronological systems.

Another problem right on the borderline between Phase I, learning, and Phase II, unlearning, is that of therapeutic sterility, that is, what is advisable for the doctor to do or to avoid doing when treating a patient. Here, too, we analysts have been able to formulate a set of guiding principles to safeguard the recognition and working through of the patient's transference. It was found that in our research-cum-training seminars all these rules and precepts, so important in the analytic practice, had to be re-examined and often fundamentally re-formulated so as to make them meaningful for other forms of medical setting. To quote three striking examples, in the practice of a paediatrician, a cardiologist or a gynaecologist, quite different rules must obtain than in the psycho-analytical situation. Although both patient and doctor behave according to different rules in each of these settings, if the transference is handled properly, its therapeutic effect will be considerable. This means that the rules of propriety for dealing with the transference have to be re-formulated for every medical setting in order that they should be as meaningful as they are for our psycho-analytical setting. This is a most promising task but it can be undertaken only if no member of the research team tries to impose his superiority on the others.

Perhaps the most difficult task is to realize the limitations of our way of thinking which is still much too much under the influence of illness-centred medicine. On the whole, we psychiatrists are very proud of our new nosology and the new therapy developed on that basis. Many excellent clinicians among us joined hands to isolate certain, fairly well-defined, pathological entities out of the hazy conglomerates of the Edwardian era. These clinical entities, like depression, anxiety states, agitation, the much more sharply defined schizophrenia, and so on, led in a number of cases to an easier diagnosis and to a much more efficient therapy. However, we should not forget that all these new, or re-formulated entities still belong to the illness-orientated medicine and represent not much more than a newer edition of such now defunct, but once highly respectable entities as neurasthenia, psycho-asthenia, and so on, though using this new nosology, it is not too difficult to reach a diagnosis and on that basis, to devise a reactional therapy, we must not forget that all this is still within the limits of illness-orientated medicine and, in consequence, its efficiency will not extend much beyond the field of Class I conditions. If one wishes to help the considerable number of patients suffering from Class II and mixed conditions, a new psychiatry must be developed based on overall diagnosis under the aegis of the patient-orientated medicine.

Summary

1. The traditional postgraduate or refresher courses are run exclusively by specialists and are structured according to the teacher-pupil relationship. Because of this structure, they reinforce respect for the teacher-specialist and for 'hospital' medicine.
 2. The research-cum-training method aims at establishing equality among the members of the research team and thus encourages critical scrutiny instead of respect. The price for it is the acceptance by the doctor of an increased responsibility.
 3. A short description is given of the three phases of the training experience as they became observable in the development of the research-cum-training programme.
 4. The consequences and implications of the new ideas and skills for medical practice are briefly surveyed.
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